The Quality Payment Program: Year 2 (2018) Overview

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Important Note: Sections of this presentation were developed in collaboration with Centers for Medicare & Medicaid Services (CMS).

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Some slides are courtesy of CMS from various CMS webinars and presentations about the Quality Payment Program.
Objectives

1. Identify the background and purpose of the Quality Payment Program (QPP): Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.
2. Identify framework paths: Merit Based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (APMs).
3. Discuss payment adjustments and bonuses related to MIPS and APMs.
4. Discuss Final Rule with comments Year 2 (Performance Year 2018).
5. Identify steps to prepare for the QPP within the IHS.
Quality Payment Program Overview
Origin of the Quality Payment Program (QPP)

- Bipartisan Legislation
- **Repeals** the Sustainable Growth Rate (SGR) Formula
- Increases focus on quality of care and value of care delivered
- Moving towards patient-centric health care system
  - Delivers better care
  - Smarter spending
  - Healthier People
- **Offers two tracks of participation**
Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

CMS is issuing an interim final rule with comment period (IFC) that addresses extreme and uncontrollable circumstances MIPS eligible clinicians may face as a result of widespread catastrophic events affecting a region or locale in CY 2017, such as Hurricanes Irma, Harvey and Maria.

See the Final Rule for information on submitting these comments by the close of the 60-day comment period on January 1, 2018 no later than 5 p.m. ET. When commenting refer to file code CMS 5522-FC.

DATES: Effective Date: These provisions of this final rule with comment period and interim final rule with comment period are effective on January 1, 2018.

Quality Payment Program: Two Participation Tracks

Health care providers to take part in CMS’ quality programs in one of two ways:

1. Merit-Based Incentive Payment System (MIPS)
2. Advanced Alternative Payment Models (Advanced APMs)

**MIPS**

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

**Advanced APMs**

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.
Currently there are **multiple quality and value reporting programs** for Medicare clinicians.

The Quality Payment Program/ MACRA streamlines (combines) legacy programs into a single, improved reporting program = **MIPS**
Which clinicians does The Quality Payment Program affect?
(Will it affect me?)

Short answer: Quality Payment Program affects clinicians who participate in Medicare Part B.
MIPS Quality Payment Program
Eligibility

For 2017 and 2018, types of clinicians:

- Physician
  - Doctors of Medicine
  - Doctors of Osteopathy
- Dentists
- Optometrists
- Chiropractors
- Podiatrists
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

*No change in the types of clinicians eligible to participate in 2018*
Who is included in MIPS? (2017 & 2018)

**Change to the Low-Volume Threshold for 2018.** Includes MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.

Transition Year 1 (2017) Final  
BILLING $>30,000 AND >100

Year 2 (2018) Final  
BILLING $>90,000 AND >200

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.
What is MIPS (2017)

MIPS participants receive a payment adjustment based on performance in four categories

<table>
<thead>
<tr>
<th>Quality</th>
<th>Cost</th>
<th>Improvement Activity</th>
<th>Advancing Care Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replaces PQRS</td>
<td>Replaces Value-Based Modifier</td>
<td>New performance category</td>
<td>Replaces the EHR Incentive Program</td>
</tr>
<tr>
<td>Assesses the value of care to ensure patients get the right care at the right time.</td>
<td>Supports: Care coordination, Beneficiary engagement, Population management, Patient safety</td>
<td>Supports the secure exchange of health information and the use of certified EHR technology</td>
<td></td>
</tr>
<tr>
<td>60% of MIPS Score</td>
<td>0% of MIPS Score</td>
<td>15% of MIPS Score</td>
<td>25% of MIPS Score</td>
</tr>
</tbody>
</table>
MIPS Performance Categories Transition Year (2017)

How will physicians and practitioners be scored under MIPS?

A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

<table>
<thead>
<tr>
<th>Quality</th>
<th>Cost</th>
<th>Improvement Activities</th>
<th>Advancing Care Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>*Cost</td>
<td>Improvement Activities</td>
<td>Advancing Care Information</td>
</tr>
</tbody>
</table>

*Cost = 0 % weighting the first year
MIPS Performance Categories for Year 2 (2018)

Comprised of four performance categories in 2018.

**So what?** The points from each performance category are added together to give you a MIPS Final Score. Performance threshold set at 15 points.

The MIPS Final Score is compared to the MIPS performance threshold to determine if one receive a positive, negative, or neutral payment adjustment.
Who is Exempt? MIPS Year 2 (2018)

**No Change in Basic Exemption Criteria***

- Newly-enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to **$90,000** a year
  - OR
  - See **200** or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of their Medicare payments
  - OR
  - See 20% of their Medicare patients through an Advanced APM

*Only Change to Low-volume Threshold*
What is a Virtual Group?

Year 2 (2018): Added **Virtual Groups** as a way to participate

- Solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period of a year.

- Solo practitioners and small groups may only participate in a Virtual Group if they exceed the low-volume threshold.

- Are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.

- Election period is October 11, 2017 to **December 31, 2017**, for the 2018 MIPS performance period.

- To learn more, see the [2018 Virtual Groups Toolkit](#).
If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

**Options**

- **Individual**
  - Under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

- **Group**
  - As a Group
    - Two or more clinicians identified by their National Provider Identifier (NPIs) who have reassigned their billing rights to a single Tax Identification Number (TIN)*.
    - As an APM Entity

- **Virtual Group**
  - As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.
**MIPS Year 2 (2018) Performance Period**

**Change:** Increase to Performance Period

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Performance Category</strong></td>
<td><strong>Minimum Performance Period</strong></td>
</tr>
<tr>
<td>Quality</td>
<td>90-days minimum; full year (12 months) was an option</td>
</tr>
<tr>
<td>Cost</td>
<td>Not included. 12-months for feedback only.</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>90-days</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>90-days</td>
</tr>
</tbody>
</table>
No change: All of the submission mechanisms remain the same from Year 1 to Year 2

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Mechanisms for Individuals</th>
<th>Submission Mechanisms for Groups (Including Virtual Groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>QCDR</td>
<td>QCDR</td>
</tr>
<tr>
<td></td>
<td>Qualified Registry</td>
<td>Qualified Registry</td>
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<td></td>
<td>EHR</td>
<td>EHR</td>
</tr>
<tr>
<td></td>
<td>Claims</td>
<td>CMS Web Interface (groups of 25 or more)</td>
</tr>
<tr>
<td>Cost</td>
<td>Administrative claims</td>
<td>Administrative claims (no submission required)</td>
</tr>
<tr>
<td></td>
<td>(no submission required)</td>
<td></td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Attestation</td>
<td>Attestation</td>
</tr>
<tr>
<td></td>
<td>QCDR</td>
<td>QCDR</td>
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<tr>
<td></td>
<td>Qualified Registry</td>
<td>Qualified Registry</td>
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<tr>
<td></td>
<td>EHR</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>Advancing Care Information</td>
<td>Attestation</td>
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<tr>
<td></td>
<td></td>
<td>CMS Web Interface (groups of 25 or more)</td>
</tr>
</tbody>
</table>
Incentives for Advanced APM Participation
What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

As defined by MACRA, APMs include:

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by federal law

MACRA **does not change how any particular APM rewards value**. APM participants who are not “QPs” will receive **favorable scoring under MIPS**. Only **some** of these APMs will be **Advanced** APMs.
Rewards for APM Participants

QPP provides additional rewards for participating in APMs.

Potential financial rewards

Not in APM

In APM

In Advanced APM

MIPS adjustments

MIPS adjustments

+ APM-specific rewards

+ APM-specific rewards

5% lump sum bonus

If you are a qualifying APM participant (QP)
Putting It All Together 2017 and Beyond
Quality Payment Program: Pick Your Pace (CY 2017)

- Ready- Begin January 1, 2017
- Not Quite Ready
- Send in Performance Data by March 31, 2018
Don’t Participate | Submit Something | Submit a Partial Year | Submit a Full Year

Positive adjustments are based on performance data from the performance information submitted—
Not the amount of information or the length of times submitted.
Putting it all together

Fee Schedule

<table>
<thead>
<tr>
<th>Year</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026 &amp; on</th>
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<tbody>
<tr>
<td>+0.5% each year</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
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<td>+0.25% or 0.75%</td>
</tr>
</tbody>
</table>

MIPS

Max Adjustment (+/-)

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<tbody>
<tr>
<td>4</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>9</td>
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</tbody>
</table>

QP in Advanced APM

+5% bonus (excluded from MIPS)
Additional Information:
Quality Payment Program Year 2 (2018)

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Chief Health Informatics Officer
CMS Final Rule for QPP Year 2 (2018) Fact Sheet

- 26 pages
- Provides comparison summary
- Example of changes provided such as adding virtual groups for 2018.

## Comparison- Quality

|---------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Weight to final score | • 60% in 2019 payment year.  
• 50% in 2020 payment year.  
• 30% in 2021 payment year and beyond.                                           | • 50% in 2020 payment year.  
• 30% in 2021 payment year and beyond. SAME                                        |
| Data completeness:  | Measures that do not meet the data completeness criteria receive 3 points.                      | Measures that do not meet data completeness criteria will earn 1 point instead of 3 points, except measures submitted by small practices will continue to earn 3 points. |
## Comparison - ACI

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Weight to final score</td>
<td>• 25%, made up of a base score, performance score, and bonus points for data submission on certain measures and activities.</td>
<td>• No change for the 2020 payment year.</td>
</tr>
<tr>
<td>Bonus</td>
<td>• Bonus (5%) for reporting to 1 or more additional public health and clinical data registries.</td>
<td>• A 5% bonus score is available for submitting to an additional public health agency or clinical data registry not reported under the performance score.</td>
</tr>
<tr>
<td></td>
<td>• Bonus (10%) for completion of at least 1 of the specified Improvement Activities using CEHRT.</td>
<td>• Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus if CEHRT used to complete at least 1 of the specified Improvement Activities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A 10% bonus score for using 2015 Edition exclusively.</td>
</tr>
</tbody>
</table>
Comparison- ACI
(continued)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Reweighting/Hardship exceptions</td>
<td>• Allowed reweighting of the Advancing Care Information category to 0, if there are insufficient measures applicable and available to MIPS eligible clinicians.</td>
<td>Based on authority from the 21st Century Cures Act, CMS will reweight the Advancing Care Information performance category to 0% of the final score and reallocate the performance category weight of 25% to the Quality performance category for: • A significant hardship exception • A new significant hardship exception for MIPS eligible clinicians in small practices (15 or fewer clinicians); • An exception for hospital-based MIPS eligible clinicians; • A new exception for MIPS eligible clinicians whose EHR was decertified. New deadline of December 31 of the performance period for the submission of reweighting applications, beginning with the 2017 performance period.</td>
</tr>
</tbody>
</table>
### Comparison - Improvement Activity

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Weight to final score</td>
<td>• 15% and measured based on a selection of different medium and high-weighted activities.</td>
<td>No change for the 2020 payment year.</td>
</tr>
</tbody>
</table>
## Comparison- Cost

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weight to final score</strong></td>
<td>• 0% in 2019 payment year. • 10% in 2020 payment year. • 30% in 2021 payment year and beyond.</td>
<td>• 10% in 2020 MIPS payment year, but are soliciting feedback on keeping the weight at 10%.   • 30% in 2021 MIPS payment year and beyond.</td>
</tr>
<tr>
<td><strong>Measures</strong></td>
<td>• Will include the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures. • 10 episode-based cost measures. • Measures do not contribute to the score, feedback is provided for these measures.</td>
<td>• Include Medicare Spending per Beneficiary (MSPB) and total per capita cost measures in calculating Cost performance category score for the 2018 MIPS performance period. • For the 2018 MIPS performance period, CMS won’t use the 10 episode-based measures adopted for the 2017 MIPS performance period. • CMS developing new episode-based measures with stakeholder input and soliciting feedback on some of these measures - Fall 2018. • Expect proposed new cost measures in the future.</td>
</tr>
</tbody>
</table>
**Changes:** Increase in Performance Threshold and Payment Adjustment

**Transition Year 1 (2017) Final**
- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

**Year 2 (2018) Final**
- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

**How can I achieve 15 points?**
- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.
CMS knows that areas affected by the recent hurricanes, specifically Hurricanes Harvey, Irma, and Maria, have experienced devastating disruptions in infrastructure and clinicians face challenges in submitting data under the Quality Payment Program.

CMS have issued an **Interim Final Rule** with an automatic extreme and uncontrollable circumstances policy where clinicians are exempt from the Quality, Improvement Activities, and Advancing Care Information performance categories **without** submitting a hardship exception application.

**What does the Interim Final Rule mean for me in the Transition Year (2017)?**

- CMS will automatically reweight the Quality, Improvement Activities, and Advancing Care Information performance categories.
- This will result in the clinician receiving a MIPS Final Score equal to the performance threshold, unless the MIPS eligible clinician submits data.
- Clinicians who do submit data (as an individual or group) will be scored on their submitted data.
- This policy does not apply to APMs.
Extreme and Uncontrollable Circumstances in Year 2 (2018):

- The Final Rule with Comment Period for Year 2 extends the Transition Year hardship exception reweighting policy for the Advancing Care Information performance category to now include Quality, Cost, and Improvement Activities.
- This policy applies to all of the 2018 MIPS performance categories.
- A hardship exception application is required.
- The hardship exception application deadline is December 31, 2018.
Steps to Prepare for the Quality Payment Program
Getting Ready to Participate in MIPS 2017

- Determine participants eligibility status
- Choose if participants are reporting as an individual or group
- Choose participants’ submission mechanism and verify its capabilities
  - Decide if working with a third party intermediary
- Pick Your Pace (2017)
  - Choose measure(s) and activities
  - Use CMS resources (website) to explore options on measures to use
- Verify the information needed to report successfully
- Record data based on participants care for patients
- Submit data
Getting Ready to Participate in MIPS 2018

- Determine participants eligibility status
  - New eligibility Criteria
- Choose if participants are reporting as an individual or group (Virtual Group)
- Choose participants’ submission mechanism and verify its capabilities
- Follow reporting requirements (2018)
  - Follow reporting durations for performance categories (e.g. 12 months for Quality and Cost Performance Period)
Operationalize the Quality Payment Program

- IHS’s Quality Payment Program- MACRA National Working Group
- Encourage using resources - IHS Website and LISTSERV
- Provide Community Outreach - training and education
  - Webinar
  - Utilize CMS resources for technical assistance
  - Address care coordination
Future Plans for RPMS

- Perform Market Research
  - Explore what products can interface with EHR to submit CQMs

- Update Clinical Quality Measures (CQM) Logic
  - Workgroup completed initial review (high level analysis)
Additional Resource Information
Steps to Prepare for the Quality Payment Program

Utilize Quality Payment Program Resources:

  - Help and Support: https://qpp.cms.gov/about/help-and-support

- IHS Resources: https://www.ihs.gov/qpp/
Eligibility:
Check Your Participation Status

- CMS website
- CMS MIPS Participation Status

Source: https://qpp.cms.gov/
https://qpp.cms.gov/participation-lookup
Technical Assistance Support

Technical Assistance Resource Guide

- **Small, Underserved, & Rural Support (SURS)**
  - Small practices of 15 or fewer clinicians
  - Practices in rural locations, health professional shortages areas (HPSAs), and medically underserved areas (MUAs)

- **Quality Innovation Networks – Quality Improvement Organizations (QIN-QIOs)**
  - Large practice of more than 15 clinicians

- **Transforming Clinical Practice Initiative (TCPI)**

IHS QPP - MACRA Resources

IHS Website:  https://www.ihs.gov/qpp/
LISTSERV Email:  MACRA@listserv.ihs.gov
Subscribe URL:  https://www.ihs.gov/listserv/topics/signup/?list_id=357
Resources

American Medical Association. **Quality Payment Program (QPP) Specifics.** Available at: http://www.ama-assn.org/ama/pub/ad...reform.page


Centers for Medicare & Medicaid Services. **Merit-Based Incentive Payment System: Advancing Care Information Performance Category.** Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Presentation.pdf
Resources


Centers for Medicare & Medicaid Services. Quality Payment Program: Modernizing Medicare to provide better care and smarter spending for a healthier America. Available at: https://qpp.cms.gov/

Resources


Questions

susy.postal@IHS.gov